A GUIDE TO CALIFORNIA'S HEALTH CARE LICENSING BOARDS

- **a publication of a grant project entitled "Strengthening the Community's Voice on California's Health Care Licensing Boards"**

- **funded by The California Endowment**

July 2009

A GUIDE TO CALIFORNIA'S HEALTH CARE LICENSING BOARDS

TABLE OF CONTENTS

PART ONE

PART TWO

ACKNOWLEDGEMENTS

The "Strengthening the Community's Voice" project team gratefully acknowledges the support of The California Endowment, which made this *Guide* possible.

The *Guide* should be read in conjunction with its companion document, *Tapping the Full Potential of Public Members — A Tool Kit for Boards and Community-Based Organizations*. Members of the project team worked on both documents. The *Guide* was written primarily by team members Julianne D'Angelo Fellmeth, Ron Joseph, Lynn Morris, and Kathleen Hamilton. The *Tool Kit* was written primarily by Rebecca LeBuhn, David Swankin, and Mark Yessian.

The project team gratefully acknowledges the assistance of the project's Advisory Committee members, who reviewed and commented on both documents. We are also grateful to Steven Papier, Administrative Officer at the Citizen Advocacy Center, for his assistance in formatting and designing both documents; Alan Donato, who performed legal research for the *Guide*; and Christina Falcone, Executive Assistant at the Center for Public Interest Law, who handled administrative and accounting matters.

FOREWORD

This document, *A Guide to California's Health Care Licensing Boards*, is one product of a grant project called "Strengthening the Community's Voice on California's Health Care Licensing Boards" that was funded by The California Endowment in 2008–09. The *Guide* is intended to acquaint the reader with the responsibilities, governance, and operations of multi-member state boards that license and regulate practitioners who provide direct health care services to Californians. In addition, the *Guide* describes seventeen California health care licensing boards.

This *Guide* is current as of July 1, 2009. This slice of state government ─ regulatory boards that license health care providers ─ is often the subject of review and reform by the California Legislature and restructuring proposals by the Executive Branch. For example, in 2005 the Governor proposed the abolition and conversion to "bureaus" (regulatory programs headed by a single individual appointed by the Governor) of 88 California boards and commissions, including most of the boards described in this *Guide*. Although that proposal was withdrawn, the Legislature is periodically presented with proposals to consolidate or restructure these boards. As such, the reader is cautioned that the structure of these agencies is fluid and subject to change.

Individuals who are interested in becoming a member of a California health care licensing board should read this *Guide* in conjunction with *Tapping the Full Potential of Public Members — A Tool Kit for Boards and Community-Based Organizations* ("*Tool Kit*"), also a product of the "Strengthening the Community's Voice" grant project. That document is a training tool for board members and/or community-based organizations that wish to participate in board activities.

PART ONE

INTRODUCTION

Health care in California is regulated by several agencies. While the Department of Health Care Services oversees health care facilities, and the Department of Managed Health Care and the Department of Insurance oversee health plans, this *Guide* focuses on California's regulatory boards that license and regulate health care practitioners ― the people who provide direct health care services to patients, such as doctors, nurses, dentists, and pharmacists. Most of these boards are housed within the California Department of Consumer Affairs.[1]

Each of these multi-member boards is composed of licensees (health care providers who are licensed by the board on which they sit) and non-licensee "public members." The boards convene in public meetings to conduct the business of the board, make regulatory and enforcement decisions, and address other issues within their jurisdiction.

Many of the Department's health care licensing boards are over 100 years old. When they were first created by the California Legislature, they consisted solely of licensee members. For example, the first board to regulate physicians in California was established in 1876 and was comprised entirely of doctors. This composition reflected the notion, undisputed at that time, that the public is best protected through oversight conducted by professionals. It also reflected the powerful presence and influence of physician professional associations who sought to control regulation of their profession and their associates. Soon thereafter, the Legislature created similarly-composed boards to regulate dentists, pharmacists, nurses, optometrists, and other health care providers.

The all-licensee composition of California's health care boards did not change until the 1960s.

The all-licensee composition of California's health care boards did not change until the 1960s. The advent of a vigorous consumer movement in the United States challenged the assumption that the public could be protected only by professional licensees, and contended that broader representation on regulatory boards would serve the public more effectively. In 1961, the Legislature enacted a bill that changed the composition of the

[1] Some health care professionals are regulated by agencies that are not located within the Department of Consumer Affairs. For example, chiropractors are licensed by an independent Board of Chiropractic Examiners; emergency medical technicians are certified by counties under the supervision and coordination of the Emergency Medical Services Authority within the Health and Human Services Agency. This *Guide* focuses on health care boards within the Department of Consumer Affairs.

11-member medical board to allow for one non-physician "public member." Since then, the Legislature has added public members to other health care licensing boards, thereby placing a new and independent voice at the decision-making table.

Over the past four decades, the composition of the state's regulatory boards has continued to change.

Over the past four decades, the composition of the state's regulatory boards has continued to change, such that now most non-health boards consist of a majority of public members. Two of the seventeen health care boards described below (the Acupuncture Board and the Board of Vocational Nursing and Psychiatric Technicians) have a public member majority, and the percentage of public members on the other fifteen has grown from a token few to an average of 44%. As such, public members now have an opportunity to play an important role in establishing health care policy in California.

In an effort to protect the public from unqualified practitioners, California's health care licensing boards establish licensing requirements (which can include educational, practical experience, and testing requirements), establish and enforce "standards of practice" for the profession, and investigate possible violations of the board's laws, regulations, and "standards of care" which might cause harm to the public. Boards may revoke or restrict licenses in order to protect the public.

These board functions directly impact quality of health care as well as access to health care. To ensure quality and access, it is important for board members to be informed about the needs of all Californians, including the state's diverse communities that may encounter cultural and linguistic challenges as they seek adequate health care.

Aimed at community members who wish to serve as a public member on a health care licensing board, Part One of this *Guide* provides information about board responsibilities, governance, and operations; and describes the board member appointment process. Part Two of this *Guide* describes seventeen health care licensing boards within the Department of Consumer Affairs.

Most importantly, this *Guide* provides examples of actions by boards that have had a positive impact on health care access and quality. It reveals the untapped potential of this forum ― health care licensing boards ― that can and should be utilized by consumer groups, community-based organizations, and policymakers to improve the delivery of health care services to all Californians.

BOARD RESPONSIBILITIES

With one exception, each health care licensing board is created in a statute that has been passed by the California Legislature and signed by the Governor (the statute creating the Osteopathic Medical Board was contained in a 1922 initiative passed by California voters). This statute, sometimes called a board's "enabling legislation," not only sets forth the board's essential mission and scope, but may also define in part the practices that are allowed for the profession. This is sometimes called "scope of practice," and sets the boundaries for the conduct of licensees. Each board member is expected to become familiar with the legislation that has created the board on which he or she sits.

California law is clear that the primary responsibility of a health care licensing board is public protection, not protection of a profession or industry. Boards are charged with preventing significant — sometimes irreparable — harm to patients. The statute creating each board provides that "whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount."

Thus, each board is charged with regulating one or more specific professions, in order to protect patients from incompetent, dishonest, impaired, or otherwise unqualified health care providers. Regulatory boards ─ through the joint effort of appointed board members (who engage in policy and judicial decision-making) and full-time staff employed by each board (who carry out the directives of board members) ─ achieve this public protection mandate by carrying out various functions:

- They establish and enforce ***requirements for licensure***, including educational requirements, supervised practical experience (such as internships), and the passage of examinations;

- They establish and enforce ***standards of professional conduct*** that providers must follow after they are licensed;

- They ***interpret scope of practice laws*** and ***promulgate other regulations*** that spell out the rules by which licensees are expected to conduct their professions;

- They ***detect and investigate possible violations of standards*** of professional conduct, as well as of other statutory or regulatory requirements;

- They may take ***disciplinary and enforcement action*** to revoke, suspend, or restrict a license in order to protect the public;

- They engage in ***other activities*** intended to protect the public, such as requiring continuing education in order to renew licenses, maintaining Web sites that allow consumers to check the license status and disciplinary history of health care providers, engaging in public outreach and education, and proposing or commenting on legislation; and

- They participate in regular reviews of board programs through a process known as "***sunset review***." This "report card"-type review is conducted by the Legislature on a regular basis. Boards are expected to cooperate in the process, to provide requested data, and to appear before the Legislature as required.

The Licensing Function

While the broad scope of board licensing requirements is typically established by the Legislature in statute, each board adopts detailed specific requirements for licensure in its regulations. Licensing requirements are often referred to as "the three Es":

- ***Education***: The statute and regulations establish the minimum level of education required for licensure. Educational requirements may include attainment of a specific degree, and may specify that education be obtained at an "accredited" educational institution.

- ***Experience***: The statutes and regulations of several health care licensing boards require applicants for licensure to have completed practical working experience in their field. A specific number of hours of experience may be required, and applicants are typically required to perform this experience under the supervision of a licensed professional. Some health care boards allow this experience requirement to be undertaken as part of the educational requirement, while other boards require the experience requirement to be completed after the educational requirement is met.

- ***Examinations***: All applicants for licensure as a health care professional must pass one or more examinations. These examinations may be written, oral, or practical. They may be "paper and pencil" tests or computerized exams. Each board is responsible for ensuring that the exams it requires are periodically evaluated to ensure that they actually measure

the contemporary competence needed to adequately perform in the profession with safety and skill.

The policy rationale behind licensing requirements is to ensure that health care providers are competent in their professions before they offer their services, in order to prevent the sometimes irreparable harm that may occur if they are not qualified.

In the licensing area, the decisions of a regulatory board can have a profound impact on the delivery of health care services within communities. As noted above, the state has an important duty to ensure that health care providers have achieved a certain level of competence before they offer services to patients. However, increased educational or training requirements are sometimes proposed. For example, the Acupuncture Board and several acupuncturist professional associations have long advocated an increase in the Board's current 3,000-hour educational requirement to 4,000 hours. Without taking a position on that proposal, if licensing requirements become onerous or unnecessary, fewer applicants will be eligible for licensure. As fewer providers become available, already-underserved communities typically suffer the most. Thus, a crucial responsibility of a licensing board and its members is to seek balanced licensing requirements that ensure a level of skill that protects the public while not artificially limiting the number of qualified practitioners who are needed by the community.

Setting Standards of Practice

Because the regulation of health care providers is necessary to prevent irreparable harm to patients, health care licensing boards are responsible for establishing the standards of practice that apply to their licensees. These standards may, for example, limit the number of offices that each practitioner may maintain, require disclosure of certain information to patients, and/or limit the number of support staff that a practitioner may supervise.

Health care licensing boards set standards of practice in their "regulations" (also called "rules"). To establish standards of practice for their licensees, boards must engage in a public process called "rulemaking," which is governed by a statute called the Administrative Procedure Act (APA). The APA sets forth the procedures that a board must follow in adopting or amending its regulations to incorporate a standard of practice. These procedures include the following:

- ***Public notice of the proposed regulations***: The board must "publish" a notice of its intent to adopt new regulations (or change its existing regulations). This is also called a

"notice of proposed rulemaking." The notice is published in the *California Regulatory Notice Register*, a weekly state publication. In the notice, the board must notify the public that additional information is available from the board, including the board's "initial statement of reasons" for the proposed action and the actual language ("text") of the proposed changes. This notice must also be published on the board's Web site.

- ***Written comment period***: The public has a 45-day period to submit written comments on the proposed rule changes. The deadline for submitting written comments must be included in the initial notice of proposed rulemaking.

- ***Public hearing*** (optional): The board may hold a public hearing on the proposed changes. Any member of the public may submit oral comments at that time. The date, time, and place of the public hearing must be included in the initial notice of proposed rulemaking. If a board chooses not to hold a public hearing, any member of the public can compel the board to hold a public hearing by requesting one, in writing, no later than 15 days prior to the close of the 45-day written comment period.

- ***Public adoption of the proposed regulations***: Following the end of the 45-day comment period and any public hearing, the board adopts the final language of proposed changes at a public meeting. Sometimes, regulatory proposals are sufficiently complex and/or controversial that the written comment period and public hearing generate significant suggestions for modification. In those instances, the board may wish to revise (or "modify") its proposal and adopt language that differs from the original proposal. In that event, the board's staff must publish the modified language for an additional 15-day comment period.

- ***Preparation of rulemaking file***: Once the board has adopted the proposed regulatory language, its staff prepares the final rulemaking file for approval by the Department of Consumer Affairs and the Office of Administrative Law. The rulemaking file must contain a final statement of reasons, a response to every comment submitted during the 45-day written comment period and at any public hearing, and documentation of the board's compliance with the procedural requirements of the APA.

- ***Review and approval of the proposed regulatory changes***: Regulatory changes proposed by a DCA health care licensing board are subject to two levels of review. First, the Department of Consumer Affairs Director must approve the changes. The Director is

authorized to reject them if they are found to be "injurious to the public health, safety or welfare." A board may override the Director's veto with a unanimous vote of the board. The board's changes must also be approved by the Office of Administrative Law (OAL), an independent executive branch agency that is responsible for overseeing the rulemaking process. If OAL rejects a board's proposed regulations, the board is given an opportunity to address the identified deficiencies within 120 days.

The APA rulemaking process is significant to licensees, consumers, patients, and the general public. Boards are frequently given broad, sometimes vague, directives by the Legislature and delegated responsibility to flesh out the details of those directives in regulations. Because violations of the professional standards contained in a board's regulations may prompt disciplinary action against a licensee, upholding the integrity of the APA process ensures that new rules are necessary and clearly understood.

The role of board members in the rulemaking process is vital.

The role of board members in the rulemaking process is vital. Board members are expected to review comments on proposed changes. They should be prepared to ask pointed questions regarding the impact of proposed changes on the public, and they have a duty to insist on precise language. This is one of the most important functions a board member plays ─ and it is an area where the voice of public members can be critical.

Rulemaking to define the appropriate scope of practice for health care professionals is also a critical area where board member decision-making can directly influence a community's access to health care. When a board places overly strict limits on the types of services that may be offered by paraprofessionals (dental hygienists, nurse practitioners, or physician assistants, for example), the number of offices providers may have, or the number of paraprofessionals a provider may supervise, then fewer providers are available to deliver health care in underserved communities. Boards are routinely faced with these issues, and it is important that board members be informed about the potential impacts of their decisions on affected communities.

The Enforcement Function

In addition to issuing licenses and setting standards of practice, boards are also charged with detecting and investigating possible violations of those standards (as well as violations of other statutory or regulatory requirements) and taking enforcement or disciplinary action in appropriate cases to prevent future harm to the public.

The enforcement process is governed by the state Administrative Procedure Act (APA), which is intended to afford an accused licensee with a fair proceeding and an opportunity to prove that he or she did not commit misconduct or does not deserve disciplinary action.

The enforcement process involves several steps, including several in which board members do not participate:

- ***Detection***: Boards discover problem licensees through several methods. Board staff receive and review complaints and reports about their licensees filed by patients, clients, employers, insurers, other licensees, and courts. Many boards are automatically notified of criminal arrests and/or convictions of their licensees. Board staff screen these complaints and reports and determine whether they should be referred for further investigation.

- ***Investigation***: Complaints and reports that appear legitimate after this initial screening process are referred to a professional investigator for formal investigation. Some boards have their own investigative staff; other boards use investigators from the Department of Consumer Affairs. The investigator usually interviews the complainant, the accused licensee, and witnesses to the alleged misconduct. Investigators collect medical records and other documents pertaining to the incident. The investigator ultimately prepares an investigative report detailing the evidence found. Board staff review the investigative report to determine if disciplinary action is justified. If not, board staff may close the case or issue a minor sanction (such as a letter of reprimand or a fine). Board members may receive periodic reports of these matters, but are not involved in the process directly at this point.

- ***Accusation***: If the investigative report includes evidence of misconduct that is serious enough to warrant disciplinary action, the board refers the matter to a prosecutor in the Attorney General's Office. The prosecutor assigned to the case prepares and files an "accusation," the formal written complaint against the accused licensee. The licensee is notified of the filing of the accusation and may negotiate a settlement of the matter, or may choose to contest the accusation.

- ***Public hearing and proposed decision***: If the licensee wishes to contest the accusation, he or she must be given a public hearing before an administrative law judge (usually called an "ALJ") from the state Office of Administrative Hearings. At the hearing, the

board — represented by the Attorney General's Office — has the burden of proving serious misconduct by "clear and convincing evidence." The board is required to present witness testimony and documents that prove a violation of a statute or regulation. The licensee also has the opportunity to present witnesses and documents to refute the charge(s). Following presentation of all the evidence, the ALJ prepares a proposed decision. That proposed decision is then forwarded to the board members for review.

- ***Board review and adoption of decision***: This is the point at which board members become involved in the enforcement process. Board members review the ALJ's proposed decision thoroughly and determine whether to adopt it as the board's final decision in the matter. If board members believe the penalty recommended by the ALJ is too harsh, they may lower the penalty and adopt the decision. If board members believe the penalty recommended by the ALJ is too lenient, they must "nonadopt" the proposed decision and give the licensee an opportunity for additional argument before the board.

  If board members nonadopt a proposed decision, board staff order the complete record of the hearing (including a transcript of the testimony and all of the documentary evidence). Board members must review these materials and the licensee's additional argument before making a final decision in the case. On occasion, this function can become time-consuming, but it is essential to ensuring a fair decision for the licensee and protection of the public.

  Board members also review proposed "stipulated agreements" (settlements) which have been negotiated by lawyers for the board and the licensee, to determine whether they are appropriate.

- ***Court review of board decision***: Licensees may challenge board disciplinary decisions in court. Board members have no role in this process, until or unless a court reverses the board's decision, in which case the matter may appear again before the board. Board members are not generally asked to appear at court hearings on board decisions.

  Board members perform another function that is important to the enforcement process. They adopt, and periodically review and amend, the "disciplinary guidelines" that frame the basis on which board penalties are assessed. Disciplinary guidelines provide guidance to prosecutors and ALJs, as they seek appropriate, consistent resolutions of reported abuses.

The role of board members in the enforcement process is vital to fulfilling the board's public protection mandate. In enforcement proceedings, board members serve as judges who make the final board decision. In this respect, board members must ensure that their decisions are based solely on the evidence admitted by the ALJ, and not based on personal experience or knowledge, hearsay, or off-the-record communications.

The enforcement function is critical to ensuring health care quality in underserved communities. In these settings, patients may not speak English as their first language; may have little access to information about alternative providers; may be unwilling or unable to articulate a complaint if they are injured or victimized by the provider; and/or may not know where to direct such a complaint. A board's responsibility to protect patients from substandard providers extends to all California communities ― especially those who are the most vulnerable to abuse.

Other Activities

In addition to licensing, setting standards of practice, and enforcing the law, boards engage in other activities intended to protect the public and assist consumers in making informed choices.

- ***Continuing education***: The Legislature requires many health care professionals to maintain their skill and knowledge level by taking continuing education (CE) courses as a requirement for license renewal every two years. In this regard, boards may pre-approve CE courses or course providers, establish the number of CE hours required, and/or determine which courses do not meet the CE requirement.

  In this area, health care licensing board decisions can significantly impact the number and competence of providers who practice in different communities. For example, the Medical Board recently implemented legislation that requires continuing medical education courses taken by physicians in order to renew their licenses to include a component on cultural and linguistic competence.

  Some boards go beyond CE requirements to ensure "continuing competence" throughout a health care provider's career. For example, the California Board of Podiatric Medicine requires each of its licensees to demonstrate competence (through passage of an examination, completion of clinical training, or recertification by a health care facility) every ten years.

- ***Public disclosure***: All Department of Consumer Affairs health care boards maintain a Web site with a "licensee look-up" feature. This feature enables consumers to check whether a health care provider is properly licensed and whether the provider has been subject to disciplinary action. Some boards are also required to post information concerning criminal convictions, enforcement actions taken in other states, and civil malpractice judgments and settlements. Board members often become involved in determining what information the board will collect and disclose. This activity allows boards to provide information about providers that will benefit certain patient communities, such as other-than-English language proficiency and accepted insurance plans.

- ***Public outreach and education***: Boards are also responsible for conducting outreach and education to the general public in an effort to ensure that consumers know of the existence of the agency, its jurisdiction and authority, and how to access its services.

- ***Propose or comment on legislation***: Many boards ― and their members ― participate in legislative hearings, providing information on and opinions about how proposed legislation might impact the board, the public, or the profession regulated. Boards often take positions on pending legislation after discussion at a public board meeting. These discussions provide an important opportunity for representatives of community organizations to inform board members of the needs of diverse constituencies and ways in which legislation can be structured so as to promote access to competent health care.

- ***Sunset review***: Most health care boards are subject to periodic ― every four years or so ― review by the Legislature. During this process, public hearings are held by the Legislature and/or the Department of Consumer Affairs, and the board's activities and programs are reviewed in detail. Board members often participate in this process by testifying at sunset hearings. Boards are expected to fully cooperate with this review process.

BOARD GOVERNANCE

Board Composition

The composition of each health care licensing board is spelled out in the statute creating that board. The law creating each board, known as its "enabling legislation," establishes the total

number of board members. It sets forth the number of licensee members and non-licensee "public members" who sit on the board, and who appoints each member.

Board members are appointed by one of three "appointing authorities" — the Governor of California, the Speaker of the state Assembly, and the President pro Tempore (or the Rules Committee) of the state Senate. The Governor makes the majority of the appointments; and the Legislature typically appoints only public members. Once appointed, a member serves for a four-year term. When that term expires, the appointing authority responsible for that slot may reappoint the member to an additional four-year term (at most boards, members may serve for a maximum of two consecutive four-year terms) or appoint a new member to that position.

The Open Meeting Requirement

In order to carry out the functions described above, boards are required to meet and make decisions at meetings held in public. The public meeting law that applies to state boards is called the Bagley-Keene Open Meeting Act. A copy of this important law is given to every new board member upon appointment.

The Bagley-Keene Act also limits contacts between board members outside of public meetings.

The Bagley-Keene Open Meeting Act requires a board to publish a notice of any upcoming meeting at least ten days in advance of the meeting. The notice must include an agenda specifying the items to be discussed and/or decided at that meeting. Action may not be taken at board meetings on items that were not properly noticed to the public. Board agendas must provide an opportunity for "public comment" — a time when audience members, including consumers and licensees, may address the board on any matter related to its jurisdiction.

Prior to each meeting, board members receive a packet of materials, prepared by board staff, on each agenda item. These background materials are also made available to the public at board meetings. Some boards post the background materials on their Web sites.

Board members are expected to review these materials and to attend meetings prepared to discuss or make decisions, as indicated on the published agenda. Items not appearing on a board's published agenda may be discussed in part at a board meeting, but no decision on an unpublished agenda item may be made. Typically, the board president or an interested board member will move to have such an item placed on a future meeting agenda.

While most board business must be discussed in public, there are certain exceptions to the Bagley-Keene Open Meeting Act. For example, boards may discuss personnel matters, the details of licensing exams, and pending litigation in "closed session." The public is not permitted to attend closed sessions.

The Bagley-Keene Act also limits contacts between board members outside of public meetings. Although a board member may discuss an item of board business with another board member between public meetings, such contacts may not occur by telephone, email, or in person among a majority of board members. Such private efforts to get members to "agree to agree" on a position outside of a public meeting are considered violations of the Bagley-Keene Act. Intentional violation of the Act is a crime, and decisions made in violation of the Act may be voided by the courts.

Most boards meet on a quarterly basis. Between meetings, many boards work through a committee system. The board president, who is selected by the board, may appoint board members to subject-specific committees (such as licensing, continuing education, enforcement policy, or legislation) and authorize committees to meet separately from the full board to discuss assigned matters in depth. These committees are also subject to the public notice requirements of the Bagley-Keene Act. Board committees are advisory; their role is to formulate recommendations which are then submitted to the full board for discussion and possible decision at a future public meeting.

BOARD OPERATIONS

Board Members

As described above, the work performed by health care boards is vital to the health and well-being of all Californians, and all board members are expected to contribute to the board's decision-making.

However, board members are not employees of the board or of the State of California. Most licensee members are required to be actively-practicing members of their profession while they serve on a board, and public members are frequently employed full-time in other occupations. Board members are essentially volunteers who live in all parts of California. They receive no salary or benefits for their service, but do receive a $100 per day "per diem" for the days they attend board meetings, board committee meetings, or engage in other work on behalf of the

board. Board members are reimbursed for the costs of travel incurred to conduct board business, at rates established by the state.

Board Staff

To carry out its public protection mandate, each California health care regulatory board employs "staff," a group of full-time state employees who perform the day-to-day business of the board and implement its policy directives. The staff is headed by an "executive officer" who is selected and appointed by the board. The executive officer is not a member of the board. The executive officer serves "at the pleasure of the board," meaning he or she may be terminated at any time, without reason, by the board. Thus, one of a board member's important functions is selecting the executive officer and monitoring the performance of that manager. In some instances, such as the Dental Board, the Director of the Department of Consumer Affairs must approve, and may reject, the board's selection of an executive officer.

The executive officer manages the work performed by all staff, ranging from senior-level analysts and supervisors to clerical and technical employees. Staff work includes, but is not limited to, processing and verifying license applications, collecting license fees and fines, issuing license renewal notices, reviewing complaints or reports about licensees, maintaining the board's Web site, referring qualified applicants for testing, and reviewing pending legislation that might impact the board and its "stakeholders" — the public, patients, and licensees. Staff also draft proposed regulations, coordinate with Department of Consumer Affairs legal staff, and monitor the appropriate and timely processing of proposed regulations, as set forth in the APA.

Many boards also employ special staff to handle media inquiries. Occasionally, major incidents involving a board or a licensee garner significant media attention. It is important for board members to understand board policies regarding press relations. Unless specifically asked to represent the board before the media, board members are generally expected to permit the designated spokesperson to handle media requests.

As a board member, it is important and helpful to understand and respect the distinctions between staff work and board work.

As a board member, it is important and helpful to understand and respect the distinctions between staff work and board work. While board members may periodically receive reports on the status of day-to-day operations, they do not perform them. It is, however, always appropriate for a board member to inquire of the executive officer or request a staff report on a particular matter, such as the

volume of consumer complaints, a backlog of license applications or enforcement matters, or the status of implementing new legislation.

Board Funding

Funding for board operations is provided primarily through license fees paid by licensees of the board. License fees usually include an "initial license fee" (paid upon initial licensure) and "license renewal fees" (typically paid every two years). The Legislature establishes the maximum amounts a board may charge for its licenses and other services; the board then sets specific fees in regulations. These funds are considered "special funds," meaning they may only be used for board purposes and are not to be commingled with the state's other revenue sources.

The board's budget is set by the Legislature, not by the board. It is important for board members to understand that they do not control the amount of funds that may be directed for most board purposes, and they are not authorized to modify staff salaries. Board members have the opportunity to participate in legislative budget hearings, if they wish.

BOARD ACTIONS THAT HAVE IMPACTED ACCESS, QUALITY, AND COST OF HEALTH CARE

As described above, California health care licensing boards are authorized to take a variety of actions that may impact health care access, quality, and cost. Whether they exercise that authority in the public interest often depends on the will and/or energy of board members, the presence at board meetings of advocates who actively represent the public interest, and the extent to which the Legislature and the professional association(s) to which most board licensees belong support such initiatives. Following are a few examples of actions that California boards have taken in response to external advocacy or board member initiative, and that benefit California patients:

- ***Promoting medical practice in underserved communities***: Led by several physician and public members, the Medical Board of California (MBC) successfully sponsored 2002 legislation creating the California Physician Corps Loan Repayment Program, which assists recently-licensed physicians in repaying up to $105,000 in medical school loans in exchange for their agreement to practice in a medically underserved area for a minimum of three years. Since then, MBC has allocated over $5 million in physician licensing fees to the program, and individual board members have successfully sought additional

funding for the program from private foundations (including The California Endowment) and generous individuals. In 2008, MBC supported two bills (Assembly Bill 2439 and Senate Bill 1379) that now provide a permanent funding stream for this program; the Governor signed both bills.

- ***Dental patient education and choice***: In 1992, the California Legislature enacted Senate Bill 934 (Watson), a law requiring the Dental Board of California (DBC) to prepare and distribute a fact sheet comparing the risks and benefits of the most commonly-used "restorative materials" used by dentists to fill cavities. The law was intended to help inform dental patients that the most frequently used material ("amalgam" or "silver fillings") contains mercury, a toxic substance to which some patients may be allergic (or which they simply may wish to avoid). In 1993, DBC prepared a short fact sheet that the Department of Consumer Affairs later found to be inadequate and misleading; however, the Board never revised the document. In 1999, two consumer groups successfully petitioned DBC to revise the fact sheet so that it adequately informs patients of the risks and benefits of all restorative materials.

- ***Use of telemedicine to promote access to health care***: In 2007, MBC successfully sponsored Assembly Bill 329 (Nakanishi), legislation that authorizes it to establish a pilot program using telemedicine to enhance access to health care to patients with chronic diseases in medically underserved rural and urban areas. Telemedicine allows general practitioners to consult with specialists through videoconferencing which allows the specialist to see the patient, review the patient's medical records, and provide advice to the general practitioner as to the proper treatment of the patient.

- ***Reducing cost and enhancing optometric patient choice***: Prior to 2002, the Board of Optometry required optometrists to give patients a copy of their spectacle lens prescriptions but not their contact lens prescriptions. Thus, patients could shop around and purchase eyeglasses at a business (and price) of their choice, but were generally limited to purchasing contact lenses from their optometrist. After a consumer group testified during the Board's 2001 sunset review that 26 other states required optometrists to hand patients their contact lens prescriptions, the Legislature enacted Assembly Bill 2020 (Correa), which requires California optometrists to do the same. Patients are now free to purchase contact lenses from their optometrist or from another business of their choice.

- ***Understandable prescription drug labeling***: According to the American Medical Association, 46% of adults in the United States cannot understand the information on prescription drug labels. As one response to this problem, three community-based organizations successfully co-sponsored Senate Bill 472 (Corbett) in 2007. The bill requires the Board of Pharmacy to adopt regulations requiring pharmacists to use a standardized, "patient-centered" prescription drug label on all prescription drug medicine dispensed to California patients after January 1, 2011. In formulating the regulations, the Board is required to hold public forums all over the state and to consider several factors, including the needs of senior citizens and patients with limited English proficiency.

- ***Data collection on physician and dentist cultural and linguistic competency***: Prior to 2006, no health care licensing board collected data on the number and location of its licensees with other-than-English language proficiency or cultural and linguistic competency. In 2006, a California community-based organization, the Latino Coalition for a Healthy California (LCHC), successfully sponsored Assembly Bill 2283 (Oropeza), which requires the Medical Board to request information on the cultural background and language proficiency of its physician licensees when they renew their licenses every two years. Although reporting on the part of licensees is optional, the Board is required to collect all information it receives, aggregate it on an annual basis (into both statewide totals and ZIP Code of primary practice location), and publish this information on its Web site. In 2008, LCHC sponsored Assembly Bill 269 (Eng), which now requires the Dental Board to request and publish the same language proficiency and cultural background information about its dentist and dental auxiliary licensees.

These are but a few examples of the ways in which active consumer groups, community-based organizations, and board members — including public members — have influenced board decision-making to enhance health care policy in California. This forum — health care licensing boards — is underutilized by advocates, and should not be overlooked by those seeking to improve the delivery of health care services to all Californians.

BECOMING A MEMBER OF A CALIFORNIA HEALTH CARE LICENSING BOARD

If you are not already serving as a member of a California health care licensing board, we hope this *Guide* will inspire your interest in service as a board member.

Board service provides members of the community with the opportunity to contribute to the development of health care policy.

There is always a need for individuals to serve on boards — and the experience can be rewarding. Board service provides members of the community with the opportunity to contribute to the development of health care policy, to set the pace at which priorities and change occur, and in many instances to raise health care issues that have been neglected — such as ensuring the cultural and linguistic competence of health care providers throughout California's diverse communities.

If you would like to be considered for an appointment to a health care regulatory board, the first step is to identify existing board member vacancies. That information is available at www.dca.ca.gov/publications/board_members/dca_board_roster.pdf.

Additionally, you should become familiar with the boards that are seeking members. This *Guide* provides you with information about various Department of Consumer Affairs health care licensing boards. Additionally, each board maintains a Web site filled with information about its activities, meetings, and decisions.

After you submit an application to the appointing authority responsible for filling the vacancy you have selected (either the Governor, the Assembly Speaker, or the President pro Tempore of the state Senate), you may be called in for an interview, and asked if you will consent to a background check.

Remember that public members may not be a current or past licensee of the board on which they serve; nor may a public member be a close family member of a licensee of that board. Additionally, public members may not have represented (as an attorney or lobbyist) the industry regulated by the board for five years prior to appointment.

When new board members are appointed to a board, they are "sworn in" and asked to sign an oath of allegiance to uphold the United States and California constitutions. They are required to file financial disclosure statements, so that any potential conflicts of interest are known to the board and to the public, and they are required to attend training programs conducted by the Department of Consumer Affairs. The Department's training program describes the structure of California state government (with a focus on the executive and legislative branches), sets forth rules governing various board functions (such as meetings, rulemaking, and enforcement), and includes information on technical matters (such as expense reimbursement and avoidance of conflicts of interest).

PART TWO

ACUPUNCTURE BOARD

Board Responsibilities:

The Acupuncture Board is charged with licensing and regulating ***individuals who practice acupuncture and Asian medicine*** in California. California law defines "acupuncture" as "the stimulation of a certain point or points on or near the surface of the body by insertion of needles to prevent or modify the perception of pain or to normalize physiological functions, including pain control, for the treatment of certain diseases or dysfunctions of the body and includes the techniques of electroacupuncture, cupping, and moxibustion." Acupuncturists are also authorized to perform or prescribe the use of Asian massage and acupressure, breathing techniques, exercise, heat, cold, magnets, nutrition, herbs, plant, animal, and mineral products, and dietary supplements to promote, maintain, and restore health.

Board Composition:

The Acupuncture Board consists of seven members: four public members and three acupuncturists who have at least five years of experience practicing acupuncture. The Governor appoints the three acupuncturist members and two of the four public members. All members appointed by the Governor must be confirmed by the Senate. The Senate Rules Committee and the Assembly Speaker each appoint one public member.

By law, the acupuncturist members of the Acupuncture Board must "represent a cross-section of the cultural backgrounds of licensed members of the acupuncturist profession." Acupuncture Board public members may not be licensed as acupuncturists or physicians.

Board Information:

Enabling Legislation:	The Acupuncture Licensure Act, Business and Professions Code sections 4925–4979
Board Regulations:	Division 13.7, Title 16 of the California Code of Regulations
Number of Licensees:	10,000
Number of Staff:	9
Annual Budget:	$2,535,000 (2008–09)

Board Contact Information:

Janelle Wedge, Executive Officer
California Acupuncture Board
444 North Third Street, Suite 260
Sacramento, CA 95811
(916) 445-3021
www.acupuncture.ca.gov

BOARD OF BEHAVIORAL SCIENCES

Board Responsibilities:

Created in California Business and Professions Code section 4990, the Board of Behavioral Sciences (BBS) administers three statutes under which it licenses and regulates three different types of therapists who have achieved master's degree-level educational requirements and completed a prescribed number of hours of practical experience. Specifically, BBS regulates:

- ***marriage and family therapists (MFTs)***, who help individuals, couples, and groups examine interpersonal relationships in the hopes of achieving more satisfying and productive marriage and family adjustments. Under the MFT statute, BBS also regulates MFT trainees (unlicensed people who have enrolled in a master's degree program, registered with the Board, and are in the process of completing educational and experience requirements for licensure), MFT interns (unlicensed people who have completed the master's degree, registered with the Board, and are in the process of completing the experience requirement for licensure), and MFT referral services (group advertising and referral services for MFTs);

- ***licensed clinical social workers (LCSWs)***, who use their specialized knowledge of social resources, human capabilities, and behavioral motivations to aid people in making better social adjustments. LCSWs often work for government agencies and assist in providing or arranging for the provision of social services to families in need by government. Under the LCSW statute, BBS also regulates associate clinical social workers (ACSWs) (unlicensed people who have registered with the Board and are completing the experience requirement for licensure); and

- ***licensed educational psychologists (LEPs)***, who may perform a variety of professional functions pertaining to academic learning processes or the educational system, including educational evaluation; administration of diagnostic tests of academic ability, learning patterns, achievement, motivation, and personality factors; and diagnosis of psychological disorders related to academic learning processes.

Board Composition:

BBS consists of eleven members: two MFT members, two LCSW members, one LEP member, and six public members. The Senate Rules Committee and the Assembly Speaker each appoint one public member; the Governor appoints the rest of the Board's members.

Board Information:

Enabling Legislation: Business and Professions Code sections 4980–4989 (MFTs); sections 4989.10–4989.70 (LEPs); sections 4991–4998.5 (LCSWs)

Board Regulations: Division 18, Title 16 of the California Code of Regulations

Number of Licensees:
29,600 MFTs
11,642 MFT interns
17,137 LCSWs
7,891 ACSWs
1,797 LEPs

Number of Staff: 35.5

Annual Budget: $6,373,000 (2008–09)

Board Contact Information:

Paul Riches, Executive Officer
Board of Behavioral Sciences
1625 North Market Blvd., Suite S-200
Sacramento, CA 95834
(916) 574-7830
www.bbs.ca.gov

DENTAL BOARD OF CALIFORNIA

Board Responsibilities:

The Dental Board of California (DBC) licenses and regulates various types of ***dental health care professionals***, including the following:

- ***dentists***, who must graduate from a Board-approved dental college, receive a doctor of dental medicine (DMD) or doctor of dental surgery (DDS) degree, and pass an examination. Dentists are authorized to diagnose and treat, by surgery or other method, diseases, lesions, and malpositions of human teeth, alveolar process, gums, jaws, and associated structures within the oral cavity. Such diagnosis and treatment may include the use of drugs, anesthetic agents, and physical evaluation. In addition to licensing dentists who meet basic requirements, the Board issues permits to licensed dentists who complete additional coursework and/or training and who become eligible to perform oral and maxillofacial surgery, and to administer general anesthesia and/or conscious sedation to adult or pediatric patients; and

- ***dental auxiliaries***, who are authorized to perform duties under the supervision of a dentist. DBC licenses a "career ladder" of dental auxiliaries, including registered dental assistants (RDAs), registered dental assistants in extended functions (RDAEFs), registered dental hygienists (RDHs), registered dental hygienists in extended functions (RDHEFs), and registered dental hygienists in alternative practice (RDHAPs). Effective July 1, 2009, RDHs are regulated by the Dental Hygiene Committee of California (see below for a separate discussion of this new Committee).

Board Composition:

DBC consists of fourteen members: eight practicing dentist members (one of whom must be a faculty member at any California dental college, and one of whom must be a dentist practicing in a nonprofit community clinic), one RDH member, one RDA member, and four public members. The Governor appoints all eight dentist members, the RDH member, the RDA member, and two of the four public members. The Assembly Speaker and the Senate Rules Committee each appoint one public member.

Board Information:

Enabling Legislation:	The Dental Practice Act, Business and Professions Code sections 1600–1976
Board Regulations:	Division 10, Title 16 of the California Code of Regulations
Number of Licensees:	35,000 dental licenses and permits
Number of Staff:	56
Annual Budget:	$9,906,864 (2008–09)

Board Contact Information:

Cathleen Poncabare, Executive Officer
Dental Board of California
2005 Evergreen Street, Suite 1550
Sacramento, CA 95815
(916) 263-2300
www.dbc.ca.gov

DENTAL HYGIENE COMMITTEE OF CALIFORNIA

Committee Responsibilities:

Within the jurisdiction of the Dental Board of California, the Dental Hygiene Committee of California (DHCC) ― effective July 1, 2009 ― licenses and regulates registered dental hygienists (RDHs), registered dental hygienists in alternative practice (RDHAPs), and registered dental hygienists in extended functions (RDHEFs); reviews and approves professional education programs; establishes continuing education requirements and programs for licensees; and makes recommendations to the Dental Board regarding scope of practice issues.

The practice of dental hygiene includes dental hygiene assessment and the development, planning, and implementation of a dental hygiene care plan; and oral health education, counseling, and health screenings. Under the general supervision of a dentist, an RDH may perform preventive and therapeutic interventions, including oral prophylaxis, scaling, and root planing; apply agents used for the control of caries and periodontal disease; and take impressions for bleaching trays. Under the direct supervision of a dentist and as approved by the DHCC, an RDH may additionally perform soft-tissue curettage; administer local anesthesia; and administer nitrous oxide and oxygen.

Committee Composition:

The DHCC consists of nine members: four RDH members (of these, one must be either an RDHAP or RDHEF; one must be a dental hygiene educator; and two must be RDHs); one practicing dentist who holds a current California license; and four public members. All DHCC members are appointed by the Governor.

Committee Information:

Enabling Legislation:	Business and Professions Code sections 1900–1966.6
Committee Regulations:	Division 10, Title 16 of the California Code of Regulations
Number of Licensees:	17,052
Number of Staff:	4
Annual Budget:	$1,500,000 (2008–09)

Committee Contact Information:

Lori Hubble, Executive Officer
Dental Hygiene Committee of California
2005 Evergreen Street, Suite 1050
Sacramento, CA 95815
(916) 263-1978
www.dhcc.ca.gov

MEDICAL BOARD OF CALIFORNIA

Board Responsibilities:

Originally created in 1876, the Medical Board of California (MBC) licenses and regulates ***medical doctors*** ("MDs," who are called "physicians and surgeons" in California law) to practice medicine in California. (Osteopathic medical doctors, called "DOs" or "doctors of osteopathic medicine," are licensed and regulated separately by the Osteopathic Medical Board of California; see below for information on that board.) Physicians are highly trained medical practitioners who treat injury and illness by performing diagnostic tests and evaluations, prescribing medication, performing surgery, and providing other medical services and advice.

MBC's physician licensing program ensures that all individuals licensed by the Board meet minimum requirements established by law for education and training. The Board's enforcement program provides two types of consumer services: (1) it receives, investigates, prosecutes, and ― in appropriate cases ― takes disciplinary action against the licenses of physicians who are incompetent, negligent, impaired, and/or dishonest; and (2) it discloses information about physicians to consumers.

MBC also licenses and regulates certain other allied health care professions, including the following:

- ***licensed midwives*** may ― under the supervision of a licensed physician in active practice ― attend cases of normal childbirth in a home, birthing clinic, or hospital environment;

- ***research psychoanalysts*** are graduates of an approved psychoanalytic institute who engage in psychoanalysis as an adjunct to teaching, training, or research, and who hold themselves out as psychoanalysts; and

- ***registered dispensing opticians*** (RDOs) are individuals, corporations, or firms that are engaged in the business of filling prescriptions of physicians or optometrists for prescription lenses and similar products. The Board's RDO licensing program also includes separate registration programs for spectacle lens dispensers, contact lens dispensers, and nonresident contact lens sellers.

Additionally, MBC regulates ***medical assistants***, unlicensed individuals who perform non-invasive routine technical support services under the supervision of a licensed physician or doctor of podiatric medicine in a medical office or clinic setting.

Board Composition:

MBC consists of fifteen members: eight physicians and seven public members. The Governor appoints all eight physician members and five of the seven public members; the Governor's appointees to MBC must be confirmed by the Senate. The Assembly Speaker and the Senate Rules Committee each appoint one public member to MBC.

Board Information:

Enabling Legislation:	The Medical Practice Act, Business and Professions Code sections 2000–2448
Board Regulations:	Division 13, Title 16 of the California Code of Regulations
Number of Licensees:	124,000 physicians 171 licensed midwives 81 research psychoanalysts 1,164 registered dispensing opticians
Number of Staff:	250
Annual Budget:	$52,000,000 (2008–09)

Board Contact Information:

Barb Johnston, Executive Officer
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(916) 263-2389
(800) 633-2322 (toll-free complaint line)
www.mbc.ca.gov

BOARD OF REGISTERED NURSING

Board Responsibilities:

The Board of Registered Nursing (BRN) regulates the practice of registered nurses and certified "advanced practice" nurses in order to protect the public. California's Nursing Practice Act defines the practice of "nursing" as "those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill."

BRN licenses and regulates registered nurses and certifies advanced practice nurses in the following areas:

- a ***registered nurse (RN)*** may provide direct and indirect patient care that includes the administration of medications ordered by and within the scope of licensure of a physician, dentist, doctor of podiatric medicine, or clinical psychologist; perform skin tests and immunization techniques, and withdraw blood from veins and arteries; and perform other patient care services pursuant to "standardized procedures" (policies and protocols developed by health care facilities and organizations through collaboration among administrators and health professionals, including physicians and nurses);

- a ***certified nurse midwife (CNM)*** may ― under the supervision of a licensed physician ― attend cases of normal childbirth and provide prenatal, intrapartum, and postpartum care, including family planning care for mothers and immediate care for newborns;

- a ***certified nurse anesthetist (CRNA)*** is an RN who provides anesthesia services under the direction of a physician, dentist, or doctor of podiatric medicine;

- a ***nurse practitioner (NP)*** has an active RN license and a master's degree in nursing or a clinical field related to nursing, and is authorized to (among other things) furnish or order certain drugs and devices pursuant to a standardized procedure and under the general supervision of a physician;

- a ***public health nurse (PHN)*** is an RN who practices in the public health community and provides direct patient care as well as services related to maintaining public health, including control and prevention of communicable disease; promotion of maternal and child health; prevention of abuse and neglect of children, elders, and spouses; and outreach screening, case management, resource coordination and assessment, and delivery and evaluation of care for individuals, families, and communities; and

- a ***clinical nurse specialist (CNS)*** is an RN who holds a master's degree in a specific clinical field and who participates in expert clinical practice, education, research, consultation, and clinical leadership in clinical care specialties established by the Board.

Board Composition:

BRN consists of nine members: five RN members and four public members. Two of the RN members must be actively performing direct patient care; one RN member must be active as an educator or administrator of an approved nursing program; one RN member must be an administrator of a nursing service; and one RN member must be an advanced practice nurse. The Governor appoints the RN members and two of the four public members; the Assembly Speaker and the Senate Rules Committee each appoint one public member.

Board Information:

Enabling Legislation:	The Nursing Practice Act, Business and Professions Code sections 2700–2838.4
Board Regulations:	Division 14, Title 16 of the California Code of Regulations
Number of Licensees:	363,000 RNs 15,400 NPs 1,200 CNMs 2,000 CRNAs 49,000 PHNs 2,800 CNSs
Number of Staff:	90
Annual Budget:	$24,100,000 (2008–09)

Board Contact Information:

Executive Officer
Board of Registered Nursing
1625 North Market Blvd., Suite N217
Sacramento, CA 95834
(916) 322-3350
www.rn.ca.gov

BOARD OF OCCUPATIONAL THERAPY

Board Responsibilities:

Established in 2001, the Board of Occupational Therapy (BOT) is responsible for the licensure and regulation of ***occupational therapists (OTs)*** and ***occupational therapy assistants (OTAs)*** in California.

Occupational therapy was established in 1917 to treat World War I soldiers and is one of the oldest allied health professions in the United States. Occupational therapists used functional activities to increase the independence of veterans who were returning from the European warfront with physical and psychological trauma. Today, occupational therapy practitioners provide health and rehabilitation services to people of all ages who ― because of illness, injury, or developmental or psychological impairment ― need specialized intervention to regain, develop, or build skills necessary for independent functioning. The focus of occupational therapy is on an individual's ability to effectively engage in performance areas that are purposeful and meaningful, such as activities of daily living, work, and other productive activities. Occupational therapists evaluate and treat sensorimotor, cognitive, and psychosocial problems that interfere with an individual's ability to perform in their specific environment.

Board Composition:

BOT consists of seven members: three OT members, one OTA member, and three public members. The Governor appoints the OT members, the OTA member, and one public member. The Assembly Speaker and Senate Rules Committee each appoint one public member to the Board.

Board Information:

Enabling Legislation:	The Occupational Therapy Practice Act, Business and Professions Code sections 2570–2571
Board Regulations:	Division 39, Title 16 of the California Code of Regulations
Number of Licensees:	10,000
Number of Staff:	6.5
Annual Budget:	$1,087,000 (2008–09)

Board Contact Information:

Heather Martin, Executive Officer
Board of Occupational Therapy
2005 Evergreen Street, Suite 2050
Sacramento, CA 95815
(916) 263-2294
www.bot.ca.gov

BOARD OF OPTOMETRY

Board Responsibilities:

The Board of Optometry licenses and regulates optometrists (also called "optometric doctors" or "ODs") ― independent, primary health care providers who conduct eye examinations to detect vision irregularities and to determine the overall health of the eyes. In addition to prescribing corrective lenses when needed, optometrists screen for diseases such as glaucoma, cataracts, macular degeneration, hypertensive retinopathy, and diabetic retinopathy. The Board issues certifications to optometrists who become eligible to prescribe therapeutic pharmaceutical agents ("TPA") and/or to treat glaucoma patients over the age of 18 (called "TPA with glaucoma certification" or "TPG").

Board Composition:

The Board of Optometry consists of eleven members: six OD members and five public members. The Governor appoints all of the OD members and three of the public members; the Assembly Speaker and the Senate Rules Committee each appoint one public member to the Board.

Board Information:

Enabling Legislation:	The Optometry Practice Act, Business and Professions Code section 3000–3167
Board Regulations:	Division 15, Title 16 of the California Code of Regulations
Number of Licensees:	6,800
Number of Staff:	8.5
Annual Budget:	$1,500,000 (2008–09)

Board Contact Information:

Mona Maggio, Executive Officer
Board of Optometry
2420 Del Paso Road, Suite 255
Sacramento, CA 95834
(916) 575-7170
www.optometry.ca.gov

OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA

Board Responsibilities:

The Osteopathic Medical Board of California (OMBC) was established in 1922 when the Osteopathic Initiative Act was approved by California voters. The Act created a board to license and regulate ***doctors of osteopathic medicine (DOs)***, whose medical education, clinical training, and professional status are equivalent to those of medical doctors in California. (Medical doctors, called "MDs," are licensed and regulated separately by the Medical Board of California; see above for information on that board.)

DOs are fully educated and licensed to practice all aspects of medicine; they are specially trained to perform osteopathic manipulative treatment, a method in which they use their hands to diagnose and treat the patient, giving particular attention to muscles, nerves, joints, and bones. Osteopathic physicians adhere to a philosophy of medicine that focuses on the unity of all body parts, recognizes the body's ability to heal itself, and strives to prevent disease and conditions before they occur (instead of treating them once they occur).

Board Composition:

OMBC consists of seven members: five DO members and two public members. The Governor appoints all OMBC members.

Board Information:

Enabling Legislation:	The Osteopathic Act, Business and Professions Code sections 3600–3600.5 [Note: DOs are also subject to various sections of the Medical Practice Act, including Business and Professions Code sections 2450–2459.7.]
Board Regulations:	Division 16, Title 16 of the California Code of Regulations
Number of Licensees:	5,258
Number of Staff:	7
Annual Budget:	$1,408,000 (2008–09)

Board Contact Information:

Donald Krpan, DO, Executive Officer
Osteopathic Medical Board of California
1300 National Drive, Suite 150
Sacramento, CA 95834
(916) 928-8390
www.ombc.ca.gov

BOARD OF PHARMACY

Board Responsibilities:

The Board of Pharmacy protects consumers by licensing and regulating ***all aspects of the practice of pharmacy*** in California, including pharmacists, pharmacies, and prescription drugs and devices. The Board also regulates drug wholesalers, specialized facilities, and other practitioners (such as pharmacist interns and pharmacy technicians). The Board licenses more than 100,000 individuals and firms, and administers and enforces 12 regulatory programs.

Board Composition:

The Board of Pharmacy consists of thirteen members: seven pharmacist members and six public members. At least five of the pharmacist members must be actively engaged in the practice of pharmacy. Additionally, the membership of the Board must include at least one pharmacist representative from each of the following practice settings: an acute care hospital, an independent community pharmacy, a chain community pharmacy, and a long-term health care or skilled nursing facility. The pharmacist appointees must also include a pharmacist who is a member of a labor union that represents pharmacists. The Governor appoints the seven pharmacist members and four of the six public members; the Assembly Speaker and the Senate Rules Committee each appoint a public member to the Board.

Board Information:

Enabling Legislation:	The Pharmacy Law, Business and Professions Code sections 4000–4426
Board Regulations:	Division 17, Title 16 of the California Code of Regulations
Number of Licensees:	113,000
Number of Staff:	60
Annual Budget:	$9,700,000 (2008–09)

Board Contact Information:

Virginia Herold, Executive Officer
Board of Pharmacy
1625 N. Market Blvd., Suite N219
Sacramento, CA 95834
(916) 574-7900
www.pharmacy.ca.gov

PHYSICAL THERAPY BOARD OF CALIFORNIA

Board Responsibilities:

The Physical Therapy Board of California (PTBC) licenses and regulates ***physical therapists (PTs)***, who provide physical therapy services after a diagnosis by a health care provider who is qualified to diagnose (such as a physician, dentist, doctor of podiatric medicine, or chiropractor); and ***physical therapist assistants (PTAs)***, who provide physical therapy care under the supervision of a PT. Additionally, the Board oversees the scope of practice of unlicensed physical therapy aides, who assist a PT under the direct and immediate supervision of the PT.

California law defines physical therapy as "the art and science of physical or corrective rehabilitation or of physical or corrective treatment of any bodily or mental condition of any person by the use of the physical, chemical, and other properties of heat, light, water, electricity, sound, massage, and active, passive, and resistive exercise, and shall include physical therapy evaluation, treatment planning, instruction and consultative services. The practice of physical therapy includes the promotion and maintenance of physical fitness to enhance the bodily movement related health and wellness of individuals through the use of physical therapy interventions."

Board Composition:

PTBC consists of seven members: four PT members and three public members. One of the PT members must be involved in the education of PTs. The Governor appoints the four PT members and one of the public members; the Assembly Speaker and the Senate Rules Committee each appoint one public member to the Board.

Board Information:

Enabling Legislation:	The Physical Therapy Practice Act, Business and Professions Code section 2600–2696
Board Regulations:	Division 13.2, Title 16 of the California Code of Regulations
Number of Licensees:	21,000 PTs 5,300 PTAs
Number of Staff:	11
Annual Budget:	$2,400,000 (2008–09)

Board Contact Information:

Steve Hartzell, Executive Officer
Physical Therapy Board of California
2005 Evergreen Street, Suite 1350
Sacramento, CA 95815
(916) 561-8200
www.ptbc.ca.gov

PHYSICIAN ASSISTANT COMMITTEE

Committee Responsibilities:

The Physician Assistant Committee (PAC) of the Medical Board of California (MBC) licenses and regulates ***physician assistants (PAs)***, who are trained to provide patient evaluation, education, and health care services. Under the supervision of a physician, a PA may provide patient care services ranging from primary medicine to specialized surgical care.

To become licensed, a PA must attend a specialized medical training program associated with a medical school that includes classroom studies and clinical experience, and pass a national examination. Following licensure, each PA works under the supervision of a specific physician (either an MD licensed by the Medical Board or a DO licensed by the Osteopathic Medical Board); the supervising physician must delegate in writing those medical services, tasks, and procedures that the PA may provide. Those services may include (among others) the issuance of a drug order (including drug orders for controlled substances), the administration or provision of medication to a patient, and the performance of surgical procedures.

Committee Composition:

PAC consists of nine members: four PA members, one physician who is also a member of the Medical Board, and four public members. The Governor appoints the four PAs, the physician member, and two of the public members; the Assembly Speaker and the Senate Rules Committee each appoint one public member to PAC.

Committee Information:

Enabling Legislation:	The Physician Assistant Practice Act, Business and Professions Code sections 3500–3537.50
Committee Regulations:	Division 13.8, Title 16 of the California Code of Regulations
Number of Licensees:	7,000
Number of Staff:	5
Annual Budget:	$1,111,200 (2008–09)

Committee Contact Information:

Elberta Portman, Executive Officer
Physician Assistant Committee
2005 Evergreen Street, Suite 1100
Sacramento, CA 95815
(916) 561-8780
www.pac.ca.gov

BOARD OF PODIATRIC MEDICINE

Board Responsibilities:

The Board of Podiatric Medicine (BPM) licenses and regulates doctors of podiatric medicine (DPMs) and DPM residents; reviews and approves podiatric medical schools and postgraduate residency programs; and disciplines DPMs under the Medical Practice Act. The practice of podiatry includes the diagnosis and treatment of medical conditions of the foot, ankle, and related structures. Any procedure (including surgery) is within the DPM scope of practice if it is utilized to diagnose and treat foot, ankle, or other podiatric conditions.

Board Composition:

BPM consists of seven members: four DPM members and three public members. The Governor appoints the four DPM members and one of the public members; the Assembly Speaker and the Senate Rules Committee each appoint one public member to the Board.

Board Information:

Enabling Legislation:	Business and Professions Code sections 2460-2499.8 [Note: DPMs are also subject to various sections of the Medical Practice Act, the law that governs medical doctors.]
Board Regulations:	Division 13.9, Title 16 of the California Code of Regulations
Number of Licensees:	1,856
Number of Staff:	5
Annual Budget:	$1,312,000 (2008–09)

Board Contact Information:

Jim Rathlesberger, Executive Officer
Board of Podiatric Medicine
2005 Evergreen Street, Suite 1300
Sacramento, CA 95815
(916) 263-2647
www.bpm.ca.gov

BOARD OF PSYCHOLOGY

Board Responsibilities:

The Board of Psychology licenses and regulates the practice of ***licensed psychologists***, who have generally become eligible for licensure by achieving a qualifying doctoral degree; completing 3,000 hours of supervised professional experience; and passing several examinations. The Board also regulates ***registered psychological assistants*** (unlicensed individuals who have achieved a qualifying master's degree and are pursuing both the doctoral degree required for psychologist licensure and the required number of hours of professional experience under the supervision of a qualified licensed professional), and "***registered psychologists***" (unlicensed individuals who possess a doctoral degree which qualifies for psychologist licensure, have completed at least 1,500 hours of required supervised professional experience, and work at a nonprofit community agency that receives a minimum of 25% of its funding from a governmental source).

Psychologists differ from psychiatrists in that psychiatrists have completed a four-year medical school curriculum and are licensed as physicians by the Medical Board of California; as physicians, psychiatrists are authorized to prescribe drugs. Psychologists have achieved a doctoral degree in a qualifying subject; they are not authorized to prescribe drugs.

Board Composition:

The Board of Psychology consists of nine members: five psychologist members and four public members. The Governor appoints the five psychologist members and two of the public members; the Assembly Speaker and the Senate Rules Committee each appoint one public member to the Board.

Board Information:

Enabling Legislation:	The Psychology Licensing Law, Business and Professions Code sections 2900–2999
Board Regulations:	Division 13.1, Title 16 of the California Code of Regulations
Number of Licensees:	19,190
Number of Staff:	13.5
Annual Budget:	$3,400,000 (2008–09)

Board Contact Information:

Robert Kahane, Executive Officer
Board of Psychology
2005 Evergreen Street, Suite 1400
Sacramento, CA 95815
(916) 263-2699
www.psychboard.ca.gov

RESPIRATORY CARE BOARD

Board Responsibilities:

The Respiratory Care Board (RCB) licenses and regulates ***respiratory care practitioners (RCPs)***, who work under the direction of a physician and specialize in evaluating and treating patients who have breathing difficulties as a result of heart and lung disorders.

Respiratory care includes employing life support mechanical ventilation for patients who cannot breathe adequately on their own; administering medications in aerosol form; maintaining artificial airways (for example, tracheotomy or intubation); studying sleep disorders and disruptive sleep patterns; and conducting asthma education and smoking cessation programs. RCPs work in licensed health care facilities (including hospital settings, clinics, and skilled nursing facilities), homes, laboratories, and during the transportation of a patient.

Board Composition:

RCB consists of nine members: four RCP members, one licensed physician member, and four public members. The Governor appoints one RCP member and two public members. The Assembly Speaker appoints two RCP members and one public member. The Senate Rules Committee appoints one RCP member, the physician member, and one public member.

Board Information:

Enabling Legislation:	The Respiratory Care Practice Act, Business and Professions Code sections 3700-3779
Board Regulations:	Division 13.6, Title 16 of the California Code of Regulations
Number of Licensees:	28,000
Number of Staff:	17.5
Annual Budget:	$2,949,000 (2008–09)

Board Contact Information:

Stephanie Nunez, Executive Officer
Respiratory Care Board
444 North Third Street, Suite 270
Sacramento, CA 95111
(916) 323-9983
www.rcb.ca.gov

SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY BOARD

Board Responsibilities:

The Speech-Language Pathology and Audiology Board (SLPAB) licenses and regulates two separate professions ― speech-language pathologists and audiologists ― each with individual entry requirements, scopes of practice, and descriptive titles:

- ***Speech-language pathologists (SLPs)*** provide assessment and therapy while counseling individuals and families to better understand and deal with speech and language disorders. SLPs also evaluate and manage swallowing disorders, help victims of stroke or brain trauma regain lost language and speech, and assist those who stutter or have other speech production problems to increase their fluency and clarity of speech.

- ***Audiologists*** measure hearing sensitivity and diagnose hearing, auditory system, and balance disorders; and provide rehabilitative services (including hearing aids and other assistive listening devices), auditory training programs, and hearing conservation for individuals at risk for noise-induced hearing loss.

Board Composition:

SLPAB consists of nine members: three SLP members, three audiologist members, and three public members (one of whom must be a physician). The Governor appoints the three SLP members, the three audiologist members, the physician member, and one of the public members. The Assembly Speaker and the Senate Rules Committee each appoint one public member to the Board.

Board Information:

Enabling Legislation:	The Speech-Language Pathologists and Audiologists Licensure Act, Business and Professions Code sections 2530–2539
Board Regulations:	Division 13.4, Title 16 of the California Code of Regulations
Number of Licensees:	10,600 SLPs 1,600 audiologists 834 SLP associates 120 SLP aides
Number of Staff:	5
Annual Budget:	$811,000 (2008-09)

Board Contact Information:

Annemarie Del Mugnaio, Executive Officer
Speech-Language Pathology and Audiology Board
2005 Evergreen Street, Suite 2100
Sacramento, CA 95815
(916) 263-2666
www.slpab.ca.gov

BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS

Board Responsibilities:

The Board of Vocational Nursing and Psychiatric Technicians (BVNPT) licenses and regulates two separate professions ― licensed vocational nurses (LVNs) and psychiatric technicians (PTs) ― each with individual entry-level requirements, scopes of practice, and descriptive titles. Although both types of practitioners are licensed, neither LVNs nor PTs are independent practitioners; both work under the supervision of some other type of health care provider.

- ***Licensed vocational nurses***, under the direction of a physician or registered nurse, care for medical-surgical, maternity, and pediatric patients. They may provide basic hygiene and nursing care, measure vital signs, perform prescribed medical treatments and administer prescribed medications, and (with special Board certification) perform non-medicated intravenous therapy and blood withdrawal.

- ***Psychiatric technicians (PTs)***, under the direction of a physician, psychologist, rehabilitation therapist, social worker, registered nurse, or other professional personnel (usually the director of the facility in which they work), are responsible for the care, treatment, and rehabilitation of mentally disordered and developmentally disabled clients. With regard to these clients, a PT is authorized to provide basic hygiene and nursing care, measure vital signs, perform prescribed medical treatments and administer prescribed medications, implement behavioral management techniques, perform crisis intervention and sensory/perceptual development assessment, and (with special Board certification) perform non-medicated intravenous therapy and blood withdrawal.

Board Composition:

BVNPT consists of eleven members: six public members, three LVN members, and two PT members. The two PT members must have had at least five years of experience working at a psychiatric hospital. One member must be an LVN or registered nurse who has had at least five years of experience as a teacher or administrator in an accredited school of vocational nursing. The Governor appoints the LVN and PT members and four of the six public members; the Assembly Speaker and the Senate Rules Committee each appoint one public member to the Board.

Board Information:

Enabling Legislation:	LVNs: Business and Professions Code sections 2840–2895.5 PTs: Business and Professions Code sections 4400–4548
Board Regulations:	Division 25, Title 16 of the California Code of Regulations
Number of Licensees:	11,600 LVNs 13,000 PTs
Number of Staff:	42 for LVNs 9 for PTs
Annual Budget:	$7,200,000 for LVNs $1,656,000 for PTs

Board Contact Information:

Teresa Bello-Jones, JD, MSN, RN, Executive Officer
Board of Vocational Nursing and Psychiatric Technicians
2535 Capital Oaks Drive, Suite 205
Sacramento, CA 95833
(916) 263-7800
www.bvnpt.ca.gov